All-State Medicaid and CHIP Call
December 6, 2022

All State Call Agenda

- Mpox vaccine and PREP Act update
- Addressing Health-Related Social Needs in Section 1115 Demonstrations
- Open Mic Q and A

Mpox HHS PREP Act Declaration

- As outlined previously, mpox vaccine administration is mandatorily covered under Medicaid for beneficiaries under age 21 who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), if the mpox vaccine is determined to be medically necessary for the beneficiary based on an individualized assessment and state medical necessity criteria; otherwise, coverage is at state option.
- **On October 3, 2022, Secretary Becerra amended the Public Readiness and Emergency Preparedness Act (PREP Act) declaration for smallpox to expand the categories of providers, or "covered persons", authorized to administer vaccines and therapeutics against smallpox, mpox virus, and other orthopoxviruses in a declared emergency to include pharmacists, pharmacy technicians and pharmacy interns.**
  - Under the PREP Act amendment, the additional providers are immune from suit and liability under federal and state law with respect to all claims for loss resulting from the administration or use of a covered countermeasure if a declaration under the PREP Act has been issued with respect to such countermeasure.
- **These providers are subject to the conditions outlined in the declaration**, including certain training and supervision requirements and the requirement to provide vaccinations according to CDC/ACIP recommendations.

Mpox HHS PREP Act Declaration (cont.)

- **States generally have flexibility to set Medicaid provider qualifications**, provided that they do so in a manner consistent with the Medicaid free choice of provider requirement.

- **However, HHS PREP Act authorizations preempt conflicting state laws.** Thus, when the state covers a mpox vaccination, the state would then be required to provide a pathway to reimburse pharmacists for mpox vaccine administration, when provided in accordance with PREP Act declaration provisions.

- **States still must meet all other applicable federal requirements for covering the applicable benefit**, such as reimbursing only those providers that are enrolled as Medicaid providers and covering vaccinations only for eligible individuals.
- More context on the Medicaid implications of HHS PREP Act authorizations and Medicaid Mpox coverage be found in the:
  - CMS All-State Medicaid and CHIP Call Slides (September 13, 2022),
  - HHS Monkeypox Frequently Asked Questions For Pharmacy Partners, and
  - Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program toolkit.
  - CMS is also available to provide technical assistance about this topic.

December 6, 2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Addressing Health-Related Social Needs in Section 1115 Demonstrations

Agenda

1. **Background**
2. **Health-Related Social Needs (HRSN) 1115 Framework**
   - Covered HRSN Services
   - Service Delivery
   - Associated Fiscal Policy
   - Related Requirements
3. **State Experience: Oregon**
4. **Q&A**

Background

- In 2021, CMS **released a State Health Official (SHO) letter** that describes opportunities to address Social Determinants of Health (SDOH) in Medicaid and CHIP.
- Core to advancing equity is addressing enrollees' **health-related social needs (HRSN)** through:
  - **Care Delivery** — Transitioning to a delivery system in which states, plans, and/or providers screen for health-related social needs and act to meet those needs
  - **Quality Measurement** — Using a consistent measurement framework to create accountability for HRSN screening and success at meeting HRSN
  - **Coverage of clinically appropriate HRSN interventions** — Covering short-term, upstream, clinically appropriate HRSN interventions
- States can address SDOH through a variety of Medicaid authorities, including **state plans**, **1915(c) waivers**, **managed care in lieu of services (ILOS)** and **section 1115 demonstrations**. Several states, including **California, Massachusetts, Oregon, Arizona,** and **Arkansas**, have begun to integrate SDOH services into their state Medicaid programs through these authorities.
- In particular, some states have **used 1115 demonstration flexibilities to cover** certain evidence-based services that address SDOH, or more specifically, **health-related social needs**.
  - This option allows states to take a more **nuanced approach to defining target populations** for HRSN services than permitted through other CMS authorities
  - In order to cover HRSN services, states must agree to **additional requirements and guardrails**
  - HRSN services have **unique treatment in budget neutrality** calculations
- CMS is committed to supporting states to address HRSN, and has established a **framework to evaluate state proposals** to cover these services through 1115 demonstrations.

What are Health-Related Social Needs, and why should Medicaid address them?

- HRSN are **an individual's unmet, adverse social conditions that contribute to poor health**. These needs – including food insecurity, housing instability, unemployment, and/or lack of reliable transportation – can drive health disparities across demographic groups.
  - An individual's HRSN are **a result of their community's underlying SDOH** – the conditions in which they are born, grow, work, live, and age, and the wider set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.
- Extensive research has indicated that SDOH and associated **HRSN can account for as much as 50% of health outcomes**.[1] By addressing HRSN, state Medicaid agencies can help their members stay connected to coverage and access needed health care services.
- CMS acknowledges the important links between HRSN, health coverage, and health outcomes. Therefore, we are offering a **new 1115 demonstration opportunity to support states in addressing HRSN**, with the goals of improving coverage, access, and health equity across Medicaid beneficiaries.

[1] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

Overview: A framework for HRSN services in 1115s

Covered Services

- Housing supports
- Nutrition supports
- HRSN case management

Note: certain other HRSN services, such as transportation to HRSN-related activities, may be allowable outside of this framework

Service Delivery

- Must be medically appropriate, as determined using state-defined clinical and social risk factors
- Must be the choice of the beneficiary, who can opt-out at any time. Cannot be required or disqualify beneficiary from other services.
- Must be integrated with existing social services (e.g., HUD services, SNAP, etc.)

Fiscal Policy

- Expenditures cannot exceed 3% of state's annual total Medicaid spend
- Infrastructure costs cannot exceed 15% of total HRSN spend
- Included in the without waiver baseline for budget neutrality purposes
- State spending on related social services pre-1115 must be maintained or increased

Related Requirements

- State Medicaid reimbursement rates for primary care, behavioral health, and OB/GYN must be at least 80% of Medicare rates, or category with lowest rates must be increased by 2 percentage points
- Systematic monitoring and robust evaluation requirements, including reporting on quality and health equity measures

Nutrition Supports

The following nutrition supports will be considered under 1115 demonstrations:

Intervention	Description
1. Nutrition counseling and education	Including on healthy meal preparation
2. Medically-tailored meals	Up to 3 meals a day delivered in the home or other private residence, for up to 6 months
3. Meals or pantry stocking	For children under 21 and pregnant individuals, up to 3 meals a day delivered in the home or other private residence, for up to 6 months
4. Fruit & vegetable prescriptions and/or protein box	For up to six months

These services should **supplement, not supplant**, existing federal, state, and local nutrition supports. State Medicaid agencies should **partner with other state agencies and social service providers** to ensure that beneficiaries experiencing food insecurity are connected to programs like **SNAP, WIC,** and **TANF**.[2]

[2] SNAP: Supplemental Nutrition Assistance Program. WIC: Supplemental Nutrition Assistance Program for Women, Infants, and Children. TANF: Temporary Assistance for Needy Families.

Housing Supports (1/2)

The following housing supports will be considered under 1115 demonstrations:

Intervention	Description
1. Rent/temporary housing (+/- utilities) for up to 6 months	Limited to: individuals transitioning out of institutional care or congregate settings; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and/or youth transitioning out of the child welfare system
2. Traditional respite services	Temporary, short-term relief for primary caregivers provided by an at-home provider, a health care facility, or an adult day center
3. Day habilitation programs & sobering centers	For <24 hours, no room and board
4. Pre-tenancy & tenancy sustaining services	Including tenant rights education and eviction prevention
5. Housing transition navigation services	Including individualized case management

Housing Supports (2/2)

Intervention	Description
6. One-time transition & moving costs	Including security deposit, first month's rent, utilities activation fees, movers, relocation expenses, application and inspection fees, fees to meet identification requirements, etc.
7. Medically necessary home accessibility modifications & remediation services	Including carpet replacement, mold and pest removal, and ventilation improvements
8. Medically necessary home environment modifications	As needed for medical treatment and prevention, including air conditioners, heaters, air filtration devices, and generators

Integration with state/local housing agencies

Services and supports that can assist with obtaining and maintaining housing are a top need identified by housing and homeless services agencies.

Partnerships with state and local housing agencies are essential to success in implementation of allowable housing supports under Medicaid programs.

State and local housing agencies can play three roles:

- **Coordinating the provision of rental assistance** or affordable housing to beneficiaries who are receiving tenancy sustaining services;
- **Serving as providers** of housing navigation, pre-tenancy, and tenancy sustaining services to eligible beneficiaries;
- **Administering short-term housing assistance or one-time transition and moving costs** on behalf of a state Medicaid agency.

Medicaid-covered affordable housing supports **should supplement, but not substitute** existing housing funds. Ideally, Medicaid-covered housing supports should work seamlessly with available housing resources and programs.

Identifying and partnering with state/local housing and homeless services agencies

Agency Type	Role and Programs
State housing finance agencies (HFAs)	▪ State-chartered authorities that help finance the development of affordable housing, including administering state allocations of the federal Low Income Housing Tax Credit Program and housing bonds. ▪ Also administers HUD's HOME Investment Partnerships and Section 811 Supportive Housing Program for people with disabilities.
Public housing authorities (PHAs) 3,000+ that function statewide or cover a county/metro or municipal catchment area	▪ Oversees and manages federal public housing. ▪ Administers Housing Choice Vouchers and special purpose voucher (rental assistance) programs. ▪ Some also directly develop affordable housing.
Municipal and county government housing agencies	▪ Helps finance the development of housing. ▪ Administers federal housing capital programs like HOME, CDBG, as well as local housing resources.
Continuum of Care ~380 Continuum of Care communities that coordinate homeless services at the city, county, or regional levels	▪ Coordinate the use of federal homeless assistance grants (Continuum of Care Program grants) ▪ Coordinate homeless services programs and delivery, including through coordinated entry systems ▪ Collect and report administrative data on homeless population

Key Issues and Considerations

- Timing is everything. Until recently, most housing and homeless services agencies have been experiencing resource scarcity for rental assistance. Through the American Rescue Plan and FY 2022 appropriations, housing and homeless services agencies have experienced an influx of new resources.
- Coordinate eligibility for allowable housing supports with existing processes and systems for determining eligibility and prioritization for housing and homeless services (e.g., waiting lists and coordinated entry systems). Housing agencies typically cannot prioritize people on the basis of diagnosis or disability.
- Align short-term housing assistance with existing long-term rental assistance program requirements and processes. For example, Medicaid-covered short-term housing assistance can be administered in ways that mirrors Housing Choice Vouchers.
- Communication and collaboration require an ongoing process. An investment of time and effort to plan, implement, monitor, troubleshoot, and modify processes will increase chances of success.

Covering other HRSN services in 1115s

- CMS may consider services beyond those in the HRSN 1115 framework on a **case-by-case basis.** Other HRSN services may require different treatment for budget neutrality calculations.
- States interested in covering other HRSN services should work with their project officers to explore options within their 1115 demonstrations.

Service delivery requirements for HRSN services

- All HRSN services must be **medically appropriate**, as determined using state-defined clinical and social risk criteria. Individuals receiving HRSN services must have a **documented need for the services** in their care plan or medical record.
- HRSN services must be the **choice of the beneficiary**, who can opt-out at any time. States/managed care plans cannot condition Medicaid coverage or coverage of any benefit or service on the receipt of HRSN services, nor do HRSN services absolve the state or managed care plans from providing other medically necessary services.
- States must have **partnerships with other state and local entities** (e.g., HUD Continuum of Care Program, local housing authorities, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and/or nutrition supports.

HRSN fiscal policy

CMS has implemented specific fiscal policies for HRSN services:

- Spending cap: A state's annual **HRSN expenditure authority** (services + infrastructure) **cannot exceed 3%** of their total annual Medicaid spend.
  - Limited federal expenditure authority for **HRSN infrastructure** may be considered, but **will not exceed 15%** of the state's total HRSN expenditure authority.
- Budget neutrality: HRSN services and infrastructure expenditures will be **included as "Without Waiver" expenditures** in budget neutrality calculations. States will not be required to offset these expenditures with budget neutrality savings and will not be permitted to accrue savings if actual expenditures are lower than expected.
  - Note: At this time, any HRSN services approved outside of the CMS framework will be included as "With Waiver" expenditures and require a savings offset.
- Maintenance of effort for related social services: States must **maintain a baseline level of state funding for social services related to their approved HRSN services**. This baseline must be developed in collaboration with CMS and updated in annual monitoring reports.

Other HRSN-related 1115 requirements (1/2)

Provider Reimbursement Rates: As states increase their investments in services to address HRSN, CMS also expects states to ensure provider rates are sufficient to ensure access to basic Medicaid services.

If state's proposed annual HRSN expenditure authority equals at least $50M or 0.5% of the state's total annual Medicaid spend (whichever is less), they must meet the following requirements:

- The state's **Medicaid-to-Medicare rate ratios must be at least 80%** for **primary care**, **behavioral health**, and **OB/GYN services**. This must be measured separately for fee-for-service and managed care delivery systems, for a total of six ratios.
- States that cannot fulfill this requirement with their existing rates must commit to **increasing rates by 2 percentage points** in their lowest-performing category across any delivery systems <80% (FFS, managed care, or both). This rate increase must be implemented by the start of demonstration year 3 and be sustained throughout the demonstration.

Other HRSN-related 1115 requirements (2/2)

Monitoring and Evaluation: Similar to other 1115 demonstration authorities, HRSN services are subject to systematic monitoring and robust evaluation processes:

- In order to help identify key quality and equity gaps in state Medicaid programs, states must submit reporting to CMS on: HRSN service **implementation**, including progress made and any challenges experienced; HRSN service **utilization**; **quality** of services; and **health outcomes** for individuals receiving HRSN services.
- Evaluation must test whether HRSN services (1) **effectively address unmet HRSN**, (2) **reduce potentially avoidable, high-cost services** (e.g., ED visits, institutional care), and/or (3) **improve physical and mental health outcomes** for beneficiaries.
- State must also commit to **reporting on a slate of CMS health equity metrics** (to be defined), **stratified by race/ethnicity, language, geography, disability status, sexual orientation, and/or gender identity**. CMS will work with states on a case-by-case basis to determine feasibility of different stratifications; all states will be required to stratify across at least some of these dimensions.

State Experience with HRSN Flexibilities in 1115 Demonstrations: Oregon

2022-2027 Waiver Authorities

Health-related social needs (HRSN) benefits for individuals and families experiencing critical life transitions

Oregon will provide health-related social needs benefits – housing and nutrition services - to OHP members who are going through life transitions. These HRSN services will be Medicaid benefits.

- People who are experiencing homelessness or at risk of homelessness
- Youth with Special Health Care Needs up to age 26
- Youth who are child welfare involved
- Older adults who have both Medicaid and Medicare health insurance
- Adults and youth leaving justice involvement
- Adults leaving State Hospital

Implementation Strategies

Provider network

- Build on the existing relationships formed for HRS
- Broad benefit package available to all eligible groups
- Invest in capacity building

Partnership with Coordinated Care Orgs (CCOs) and Community Based Orgs (CBOs)

- Engage CCOs early in implementation planning
- Build on to the existing HRS delivery platform
- Provide grants to CBOs for capacity building

Collaboration w/ state agencies, counties and advocacy orgs

- Maximize and harmonize existing resources and systems
- Prevent duplication of efforts and resources

Robust identification, outreach, referral, engagement and tracking protocols

Invest in CIE technology solutions

Oregon Health Authority

Challenges

Readiness
- CBOs not familiar and prepared for billing
- Across health care and CBO partners there are severe workforce challenges

Funding and Infrastructure
- Adequate infrastructure for data sharing, information utilization and reporting/metrics
- Requires asking the legislature for funding for implementation of the benefits and infrastructure

Complexity
- Complex package of benefits and administrative complexity in delivering services
- Requires extensive internal and external collaboration with numerous critical partners – breaking down silos and facilitating new ways of working together is challenging
- We have a delivery system that includes managed care and FFS

Responsiveness
- How to ensure services are delivered in a culturally-responsive fashion
- When and how to engage community in the process – reframing our community engagement practices
- Diverse eligibility populations – distinct needs and methods for supporting

Thank you!

Updates and information:

oregon.gov/1115waiverrenewal

Reach out to us anytime:

1115waiver.renewal@odhsoha.oregon.gov

Oregon Health Authority

Q&A

Appendix: Identifying and partnering with housing and homeless services agencies

Useful links to find state and local housing agency partners:

- **State housing finance agencies** – The National Council of State Housing Agencies maintains a list of state HFAs: https://www.ncsha.org/membership/hfa-members/
- **Public housing authorities** – HUD maintains a list of public housing agencies and their contacts: https://www.hud.gov/program_offices/public_indian_housing/pha/contacts
- **Municipal or county housing agencies** – No single list. HUD municipal or county housing agencies can be found by searching for 'CDBG' and 'HOME' grantees by state: https://www.hudexchange.info/grantees/#/byState
- **Continuums of Care** – The lead agency for each Continuum of Care, also known as a 'Collaborative Applicant,' can be found by searching for 'Continuum of Care' grantees by state: https://www.hudexchange.info/grantees/#/byState